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In the Supreme Court of the United States

OCTOBER TERM, 1943

No. 395

UNITED STATES OF AMERICA, PETITIONER

v.

ELINOR CLOSE CUSHMAN, EXECUTRIX OF THE LAST WILL OF WILLIAM R. CUSHMAN, DECEASED

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE NINTH CIRCUIT

The Solicitor General, on behalf of the United States, prays that a writ of certiorari issue to review the judgment of the United States Circuit Court of Appeals for the Ninth Circuit in the above entitled case.

OPINIONS BELOW

The opinion of the District Court of the United States for the Southern District of California is not reported. It appears at R. 31–35. The opinion of the Circuit Court of Appeals for the Ninth Circuit (R. 231–234) is reported in 136 F. (2d) 815.

JURISDICTION

The judgment of the Circuit Court of Appeals was entered on June 29, 1943 (R. 234). The jurisdiction of this Court is invoked under Section 240 (a) of the Judicial Code, as amended by the Act of February 13, 1925.

QUESTIONS PRESENTED

1. Whether the United States can be estopped from claiming fraud in the procurement of a policy of Government life insurance.

2. If so, whether such an estoppel can be predicated upon the acceptance of premiums after the receipt of information by the Government which would disclose inconsistency if compared with the policy-holder's original application for insurance.

3. Whether the showing of intent to deceive flowing from proof of admittedly false statements of medical history, knowingly made in response to specific questions on an application for insurance, can be held to be overcome by evidence tending at most to show that the applicant may have considered himself in good health and his misrepresentations as unimportant.

4. Whether Rule 52 (a) of the Federal Rules of Civil Procedure has abrogated the earlier practice by which, in a trial without a jury, a motion for judgment at the conclusion of all the evidence constituted a challenge to the legal sufficiency of an opponent's case.

STATEMENT

This is a suit to recover total permanent disability benefits under a policy of government life insurance issued to William R. Cushman. After the judgment of the district court, Cushman died, and his executrix is the present respondent.

The undisputed evidence shows that in 1929 and 1930 Cushman (whom we shall refer to as respondent) "had a little trouble with constipation" and consulted a Dr. Evans at Trona, California (R. 105). Dr. Evans did not have sufficient facilities, and suggested that respondent go down to Los Angeles. At Los Angeles, respondent consulted a Dr. Godshall, who removed his tonsils (*ibid.*).[1] Since this did not relieve the constipation, Dr. Godshall sent respondent to the Cooperative Diagnostic Laboratory, where his condition was diagnosed as duodenal ulcer, and he was placed on a Sippy Diet (R. 105, 99–100). Respondent was on a diet for about a year. He then consulted with Dr. Denton, who advised him that he was not afflicted with ulcers (R. 105–106).

Respondent testified that he then "went back and forth to one doctor and the other," and finally

[1] Since it was subsequently shown that the insured's condition, in part, was nephritis, and that treatment for nephritis includes removal of all focal points of infection, such as tonsils or sinus trouble (R. 74), it is clearly inferable that the removal of the insured's tonsils was considered by the doctor as appropriate treatment for the abdominal condition of which he complained.

decided to consult the Moore-White Clinic in the fall of 1931 (R. 106). At that time, respondent declared, according to his subsequent statement to an examining physician (R. 173),—

> that he had no pep or energy, that he felt very weak all the time, had severe headaches as well as the constipation and discomfort in the bowels which he complained of before. After a careful and thorough examination he was told at the clinic that he had gastritis. He states he saw on the X-ray report "irritable stomach and colon."

The Clinic prescribed a "definite diet" (R. 106). Respondent took the Clinic's report to Dr. Denton, who then told him "There is nothing wrong with you at all," and said the diet was unnecessary (R. 106). Respondent's wife testified that he was in good health in February 1932 (R. 134).

On February 3, 1932, respondent executed his application for the policy involved in this case (R. 16–21). On the application, in answer to specific questions, he stated that he had not "*ever been treated* for any disease of" [italics supplied] the throat, stomach, liver, intestines, kidneys, or bladder (R. 20–21). The next question was (R. 21):

> Have you been ill, or contracted any disease, or suffered any injury, or been prevented by reason of ill health from attending your usual occupation, *or consulted a physician* in regard to your health, since date of discharge? [Italics supplied.]

Respondent answered this question "No" (R. 21).[2]

In the spring of the same year, 1932, respondent "began to feel much worse" and in July of that year had an attack of acute nephritis (R. 175), otherwise known as Bright's disease (R. 55). From then on he had a series of such attacks, which eventually resulted in his application for total permanent disability benefits in 1939 (R. 175–180, 185–194). He was examined by several physicians at that time, and in each instance reported the history of his case as beginning in 1929 (R. 58, 174). His statement to Dr. Stealy (R. 58) was that—

> he had no long illness until *his present trouble which started in 1929* and became very severe two years later. [Italics supplied.]

In his application for benefits, filed with the Veterans' Administration in 1939, respondent stated (R. 190–191):

> Recall no sickness except of minor nature (including a few days off for tonsillectomy)

[2] The statute authorizing the issuance of such a policy as is here sued on provides that it may be issued only to persons in good health who furnish evidence satisfactory to the Administrator of Veterans' Affairs to that effect (Section 310, World War Veterans' Act; 38 U. S. C. 512 (a)). The insured's application for the policy was upon a form provided by the Veterans' Administration, requiring statements concerning the health of the applicant, both by the applicant and by a physician (R. 16–24).

> until July 1932, although for about two years prior thereto I was having some trouble with constipation and had consulted a number of doctors, none of whom considered it of a serious nature. I did not lose any time from work on that account.

With this application was submitted the report of Dr. Stealy, which stated (R. 58):

> He had no long illness until his present trouble which started in 1929 and became very severe two years later. He had his first attack of nephritis in 1932, another in 1936, another in September 1937, one in April 1938, and in July, 1938. He was under the care of Dr. W. L. Denton of Trona, California, before coming to us.
>
> When he was examined at the Moore-White Clinic in Los Angeles, California, X-rays showed an irritable stomach with pyloric spasm, an irritable left colon and cecal stasis.

The report recited that respondent was suffering from advanced chronic gastritis, duodenitis, nephritis, and staphylococcic infection (R. 62).

The application for disability benefits was denied (R. 8–9). Respondent continued to pay premiums up to the time of trial in 1942 (R. 8).

The case was tried before a judge sitting without a jury. At the close of all the evidence, the Government moved for judgment on the ground that fraudulent misrepresentations by the insured in his application for the insurance sued on had

been conclusively established [3] (R. 221–223). The motion was denied (R. 36).

Judgment was then rendered for respondent. In its opinion (R. 31–35) and conclusions of law (R. 38) the district court held that by the acceptance of premiums after respondent's 1939 application had disclosed the facts "of the fraud now charged," the Government had elected to continue the policy and was "estopped from challenging its validity on the ground of fraud." In its finding of fact the court also found that the false statements in respondent's application for the original policy "were not made with intent * * * to defraud" (R. 37–38).

The Circuit Court of Appeals affirmed the judgment of the District Court (R. 231–234), holding that, "before ruling on the motion" for judgment, it was the duty of the court to make its findings of fact and conclusions of law, and that upon the evidence the findings of the District Court were not clearly erroneous and should not be set aside (R. 233).

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[3] The defense of fraud was not asserted in the Government's original answer (R. 5–7), and the district court denied motions by the Government for leave to amend its answer so as to raise the point shortly before the trial and for leave to amend to conform to the proof during the trial (R. 152–153, 157–165, 219–221). The evidence on the fraud point was fully presented, however, and the respondent subsequently consented to an adjudication of that issue (R. 30, 213–214). It was therefore proper for the court to decide the issue. F. R. C. P. 15 (b), 54 (c).

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SPECIFICATION OF ERRORS TO BE URGED

The Circuit Court of Appeals erred:

1. In holding that "before ruling upon the (Government's) motion" for judgment "it was the duty of the court to make and state its findings of fact."

2. In holding that there was any basis for a finding that there was no intention to defraud, despite false representations made with knowledge of their falsity.

3. In holding that the United States could waive fraud in connection with the procurement of the insurance sued upon.

4. In holding that there was any evidence from which it might be found that the United States had elected to waive fraud in the procurement of the policy sued upon.

5. In failing to direct the entry of judgment in favor of the United States.

REASONS FOR GRANTING THE WRIT

1. The decisions below present the issue whether, as a matter of law, the Government can be estopped to challenge a Government life insurance policy which would otherwise be invalid. Determination of this question, which turns upon whether the same rules of estoppel apply to the Government as to private insurance companies, is of general importance. The decision below is on this point in square conflict with the decision of the Circuit Court of Appeals for the Second Cir-

cuit in *Wilber National Bank* v. *United States*, 69 F. (2d) 526.

The District Court rested its conclusion that the Administrator of Veterans' Affairs could waive fraud in part upon the ground that "The United States in this case had a proprietary status and does not appear in its sovereignty relation" (R. 33), and the Circuit Court of Appeals presumably adopted this view, since it expressed no independent ground for its conclusion. In the *Wilber* case the court rejected the argument that the United States was "bound by the acts of its agents in the same manner as any other insurer" and held that, with respect to insurance of the character here involved, the Government acted in its sovereign capacity, and that "The law does not permit waiving statutory requirements by the acts of employees of the government" (pp. 527, 528).

In the *Wilber* case itself, this Court apparently recognized the importance of the question presented by granting the petition for a writ of certiorari, and deciding the case on the merits. 294 U. S. 120. The opinion expressly left open, however, the important question raised, inasmuch as the Court was of the view that the facts did not support an estoppel.

2. The decision below would also appear to be in conflict on its facts with the determination in the *Wilber* case when it reached this Court. Here

respondent's claim is that the Government is estopped by the acceptance of premiums after the disclosure, in the 1939 application for benefits (see pp. 5–6, *supra*), of facts inconsistent with the false statements made in the application for the policy in 1932. In the *Wilber* case the insured relied, for the establishment of an estoppel, on the acceptance of premiums after the Government should have known that the policy was no longer effective; there the Government accepted several monthly installments of the premium after the policy had expired by reason of the failure of the insured to pay an intervening installment in full. The Court held this to be an insufficient ground upon which to predicate an estoppel (294 U. S., at 124).

We think that there is even less basis for an estoppel here. Presumably the Government keeps track of the payment of premiums on its policies so that it will become aware of any default. But the Government is under no duty to assume the possibility of fraud whenever an application for disability benefits is filed. Clearly it is under no obligation to the defrauder at the earliest possible moment to compare the second application with all papers previously filed in order to protect him against the unnecessary payment of premiums.

There is no evidence in the record in this case that "the Government" or any of its officers or agents actually knew of respondent's fraud when

the premiums were accepted after 1939.[4] Such knowledge was assumed to exist from the mere transmission to the Veterans' Administration of the application containing the inconsistent facts. The Veterans' Administration, like the Government generally, operates through many agents, no one of whom may be aware of the full contents of a file built up over a period of years. It is of considerable practical importance for Government officials to know, whether, at the risk of waiving a valid defense of fraud, they are to be charged with the duty of immediately comparing an incoming statement with all material previously in the file.

The Circuit Courts of Appeals have held in similar circumstances that knowledge of the falsity of a statement in its files cannot be imputed to the Veterans Administration from inconsistent material in the files of the War Department (*United States* v. *Riggins,* 65 F. (2d) 750 (C. C. A. 9); *United States* v. *Depew,* 100 F. (2d) 725, 728 (C. C. A. 10)), of a different division of the Administration (*Halverson* v. *United States,* 121 F. (2d) 420, 422 (C. C. A. 7), certiorari denied, 314 U. S. 695), and of the contents of the files in the Administration itself touching another, but

[4] In support of his request to amend his answer the day before the trial, Government counsel stated to the district court that the facts as to the defense of fraud did not come to the attention of the Government until two days previously (R. 11; cf. R. 162–163).

closely related, matter (*Jones* v. *United States*, 106 F. (2d) 888, 891 (C. C. A. 5)). The reasoning of these cases is applicable even where inconsistent material may be found in the same file, in the absence of a showing that any Government official was aware of the inconsistency. As the Circuit Court of Appeals for the Ninth Circuit itself declared in the *Riggins* case, *supra* (at p. 751):

> We think the proposition that the government is bound by the knowledge of its officers and agents and by the contents of all its records cannot be maintained. * * *
>
> * * * * *
>
> The appellant deliberately and intentionally made a false statement in his own behalf to secure an advantage over the government of the United States. There is no reason why he should be heard to say that the government did not rely upon his statements.

3. An alternative ground of the decision below was that respondent's false answers as to past medical treatment and attendance "were not made with intent * * * to defraud" (R. 37–39, 233). The circuit court of appeals declared that the evidence supported this finding, and that it was not clearly erroneous (R. 233–234).

Ordinarily, the question whether the evidence in a particular case supports the findings and decision would not present any issue for review by this Court. If the decision below on this point has any basis whatsoever in the record, however, it presents an issue which, though factual, arises not

infrequently, and upon which the decision is in conflict with determinations of this and other courts.

There is no denial here that respondent's application for insurance contained false statements, in reference to a material fact, or that the Government relied upon them. His knowledge of the falsity is proved by his repeated subsequent contradictory statements (R. 58, 174–175, 99–100, 105–106). *Pence* v. *United States,* 316 U. S. 332, 339. The *Pence* case establishes that from such facts "the requisite intent to defraud is presumed, and therefore need not be proven in the absence of countervailing evidence" (*ibid.*).[5]

Despite the finding below, we think that we are not exaggerating when we say that there is *no evidence in the record at all,* much less sufficient to rebut a presumption to the contrary, to show that respondent had no intention to defraud—that is, to obtain a policy which he could not otherwise have secured—when he submitted false answers in his application in 1932. Only two sentences in the record can possibly be said to support the court's finding. The first is respondent's

[5] In the *Pence* case, the court did not divide on these general principles but on whether there was evidence to support the verdict of a jury. The findings of a judge, which are not protected by any constitutional requirement, are subject to a broader review by an appellate court than those of a jury. See F. R. C. P. 52, Notes, and Proceedings of Institutes on Federal Rules of Civil Procedure, Washington and New York City, pp. 286–287 (explanation of Mr. William D. Mitchell).

statement that, when he showed Dr. Denton the report of the Moore-White Clinic, the doctor said (R. 106), "There is nothing wrong with you at all." The second is his wife's testimony that "he was fine" in February 1932 (R. 134). Since the findings below have no other support, we shall assume that they are based on these remarks, and that the lower courts were of the view that such evidence supported the inference that respondent was acting in good faith.

This evidence permits at most the inference that respondent believed he was in good health in February 1932. He is not charged, however, with falsely answering question No. 25, "Are you now in good health?"[6] but the subsequent question as to whether he had "ever been treated" for specified diseases and whether he had "been ill" or "consulted a physician" (R. 20–21). A belief in one's good health does not show one's good faith in falsely denying treatment and consultation. This is especially clear when the respondent admits that he has consulted at least three doctors and two clinics with respect to serious ailments during the preceding two years.

The question as to whether a belief in one's good health negatives bad faith in falsely answering such questions is one which, though factual, is of consequence to the Veterans' Administration. The problem from its very nature is one which is

[6] Respondent answered this question "Yes."

likely to recur.[7] In the *Pence* case there was also evidence as to the insured's good health; although the opinion did not discuss the point, the statement (316 U. S., at 340 n.) "that a man is not presently disabled in no way militates against the truth of statements that he had previously consulted a physician, etc." seems inconsistent with the decision below in this case. The decision below also conflicts on this question with rulings of the Circuit Court of Appeals for the Seventh Circuit. Cf. *Perkins* v. *Prudential Insurance Co.*, 69 F. (2d) 218, 221; *Aetna Life Insurance Co.* v. *Perron*, 69 F. (2d) 401, 403–404; *Halverson* v. *U. S.*, 121 F. (2d) 420, 422, certiorari denied, 314 U. S. 695.

4. The Circuit Court of Appeals stated in its opinion that, with respect to the legal question presented by the Government's motion for judgment, "before ruling on the motion, it was the duty of the (district) court to make and state its findings of fact" (R. 233). This conclusion led the

[7] Cf. *Perkins* v. *Prudential Insurance Co.*, 69 F. (2d) 218, 221 (C. C. A. 7), in which the court stated:

"* * * The insurer has a right to know whether the insured has had occasion to consult a physician for any reason whatsoever, and to find out for itself whether or not the risk has been impaired * * *. The case at bar illustrates the necessity of that very well, for the record shows that physicians consulted by decedent found it necessary to reassure him as to his condition for the very reason that it was so serious that had he been aware of the seriousness, his worry over it would have been likely to render it even more serious. * * *"

court to treat the case as one involving only questions of fact.

It had often been held, before the new Rules, that "a motion by the plaintiff at the close of a trial without the intervention of the jury, for a declaration that he is entitled to judgment, presents a question of law which is reviewable by the appellate court." *Maryland Casualty Co.* v. *Jones,* 279 U. S. 792, 795–796, and cases cited. It is the plain import of the opinion below that Rule 52 (a) has eliminated, or rendered entirely meaningless,[8] the motion for judgment as a means of challenging the legal sufficiency of an opponent's case, even though there is no dispute with respect to any fact of legal significance. It may be doubted that the promulgation of Rule 52 (a) has had, or was intended to have, any such effect. In any event, the question as to whether it has appears sufficiently important to merit consideration by this Court.

CONCLUSION

For the reasons stated, it is respectfully submitted that this petition for a writ of certiorari should be granted.

CHARLES FAHY,
Solicitor General.

SEPTEMBER 1943.

[8] The court below treated the motion for judgment as merely a request that the case be decided on the merits in the movant's favor.

U. S. GOVERNMENT PRINTING OFFICE: 1943